

Secondary Stroke Prevention Podcast Series

Episode 3: Bridging the Gap: Overcoming Population Health Challenges in Secondary Stroke Prevention

Merged corrected transcript using revised edit timecodes

00;00;01;04 - 00;00;37;00

Craig Beavers

Welcome to the American Heart Association's Secondary Stroke Prevention Podcast Series. This episode is titled, Bridging the Gap. Overcoming Population Health Challenges in Secondary Stroke Prevention. We've hoped you've enjoyed the previous two episodes. This program is sponsored by Bayer. Content has been created and directed by a volunteer planning committee. I'm Craig Beavers. I'm a cardiovascular clinical pharmacist and researcher with Baptist Health System and the University of Kentucky College of Pharmacy. and a CV service line leader with Baptist Health System.

00;00;37;03 - 00;00;48;07

Craig Beavers

I'll be introducing today's discussion, but I'm going to allow my faculty, who is joining me, and they're very esteemed, to provide introductions to themselves. So, Ian, will you introduce yourself?

00;00;48;09 - 00;01;11;24

Thuy-Tien Ho

Yes, hi, I'm Thuy-Tien Ho. I'm a critical care physician associate in the Department of Neurology at UT Southwestern Medical Center here in Dallas. My research focuses on stroke outcomes, health disparities, and population health. I'm passionate about advancing stroke prevention through, education, clinical... through, clinicians' education, community outreach, and public health initiatives.

00;01;11;26 - 00;01;15;15

Craig Beavers

Yeah, welcome. Thank you, Tien. Welcome to the podcast.

00;01;15;17 - 00;01;40;07

Anthony Rocco

Sure, good morning. I'm Anthony Rocco, I'm the Quality Director for the Neuroscience Standardizing best practices, monitoring outcomes, data, and partnering with clinical teams to close performance gaps. So, thank you for having me today.

00;01;40;11 - 00;02;03;14

Craig Beavers

Yeah, well, I know you are very excited about this discussion. Before we get started, though, it's very important for us to give this disclaimer. The recommendations and opinions presented by our faculty and myself today are not representative of the official position of the American Heart Association. The materials are for

educational purposes only, and they do not constitute an endorsement or instruction by the American Heart Association.

00;02;03;16 - 00;02;20;12

Craig Beavers

The American Heart Association does not endorse any products or device, so with that being out of the way, let's get started. And I think if we're going to have to talk about population health. I think it really is important for everyone to be on the same page about what population health means, and knowing that there could be certain definitions. So, maybe I'm going to turn it over to you, Tien, since this is your passion and research area, for sure.

00;02;20;12 - 00;02;38;24

Craig Beavers

you know, what do we mean by population health? And then maybe if you want to more provide some color to that, when we think about stroke and secondary stroke prevention. who are those patients, and then what are the population health challenges? I know that's a big bite of ask, but let's just start out with, what do we mean by population health?

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Craig Beavers

who are those patients, and then what are the population health challenges? I know that's a big bite of ask, but let's just start out with, what do we mean by population health?

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Thuy-Tien Ho

Yes, of course, Craig. It's a big topic to cover in a few lines, but to start out with, Population Health focuses on improving outcomes across groups of people, not just individual patients. And in secondary stroke preventions, the challenge isn't that we lack effective therapies or guidelines, the challenge is actually ensuring patients can access those therapies, understanding them, and sustain them over time.

00;03;09;18 - 00;03;35;15

Thuy-Tien Ho

This is a major public health issue, because stroke remains a leading cause of disability. Approximately 800,000 Americans experience stroke each year, and millions of survivors require long-term management to reduce recurrent stroke risk. As discussed earlier in this podcast series, approximately 1 in 4 ischemic strokes, are recurrent strokes, and the risk is highest in the weeks and months following the initial events, yet despite effective therapies and strong evidence-based guidelines, recurrent stroke remains common. Therefore, here we are today.

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Thuy-Tien Ho

Well, one message that resonated with me from our first discussion was that the challenge is often not a lack of evidence, but lack of implementation, and that's the highlights of what I would like to kind of bring up today.

Population health helps us understand why evidence-based strategies do not reach every patient equally, and I hope I can cover that to some degree on today's talk. Outcomes varies across socioeconomic groups, racial and ethnic populations, geographic regions, and healthcare settings, and these differences are often reflect

00;04;01;07 - 00;04;26;17

Thuy-Tien Ho

And I hope I can cover that to some degree. On today's top outcomes varies across socioeconomic groups and ethnic populations. Here, graphic regions and health care settings. And these differences are often reflect not only clinical risk, but whether patients have the resource and the support needed to benefit from proven therapies.

00;04;26;19 - 00;04;36;20

Anthony Rocco

If I could just add to that, would you say that a way to summarize that is that so much, when it comes to population health, the gap is really in the delivery of the care on the outpatient side?

00;04;36;23 - 00;04;40;03

Thuy-Tien Ho

Yes, I have to agree with you on that totally, for sure.

00;04;40;06 - 00;05;07;04

Anthony Rocco

Yeah, it's something that I think a lot of us see, right? I think a lot of our hospitals are focusing on some of those public reporting metrics and KPIs, such as readmission, length of stay, and we're really seeing a breakdown that occurs. I think part of that issue, Tien, is that when it comes to... sorry, Tien, I stopped there. I think part of that, right, as we're all kind of getting to know each other here.

00;05;07;08 - 00;05;20;14

Anthony Rocco

Right. And we're expecting patients sometimes to sort of navigate them on instinct, right. Where the hospital functions one way, the outpatient clinic functions in another way. So hoping to get into some of that later.

00;05;20;16 - 00;05;48;20

Craig Beavers

you know, they're the funnel processes, and really understanding where amongst that funnel, or that journey, where the gaps are, the breakdown that occurs, and I think what you're... you're setting up nicely, Tony, is we're going to talk about things like you know. transitions of care and where the wheels fall off, and polypharmacy and the burden of those things. I think the.

00;05;48;24 - 00;06;08;12

Craig Beavers

I think that the challenge that exists is, you know, secondary stroke, depending on the degree and the severity of the stroke, is challenging for both the patient and the caregivers, right? There's a lot that goes into that in terms of... yeah, in terms of just... not just treatment, but to your point about rehabilitation and all the avenues and aspects. Sorry, go ahead, Tien. Yeah.

00;06;08;12 - 00;06;10;08

Craig Beavers

Sorry. Go ahead. Tim. Yeah.

00;06;10;11 - 00;06;18;04

Thuy-Tien Ho

Yes, that's correct. So, I guess which population faced the greatest challenges, and what barriers contribute to the disparities is actually why.

00;06;18;04 - 00;06;23;28

Craig Beavers

I think that's a great next step, or a great next question, right? Yeah. Yeah.

00;06;24;01 - 00;06;50;06

Thuy-Tien Ho

So, several groups actually experience greater challenges with secondary stroke preventions, including patients facing financial insecurities, lower education attainment, limited health literacy, which we're gonna also discuss in today's talk. transportation barriers, language barriers, and reduced access to specialty care. These are not, like, you know, inclusive of everything, but those are some of the factors that I want to mention.

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Thuy-Tien Ho

Historically underserved racial and ethnic populations continue to experience disproportionate stroke burden. For example, black individuals have higher stroke prevalence and mortality than white individuals. And among adults younger than 55, in the same patient population, nearly three times they have nearly three times more the stroke incidents. And then not only that, rural communities is another. Variables also face workforce shortage, longer travel distance and limited access to stroke special specialists and rehabilitation services that you mentioned earlier.

00;07;28;16 - 00;08;03;03

Thuy-Tien Ho

Workforce shortage, longer travel distance, and limited access to stroke specialists and rehabilitation service that you mentioned earlier, and when we talk about stroke disparities. And then another component is health... literacy is a major factor because it affects patients' ability to understand Risk factors, medication, and follow-up plans. Language access is another critical issue that recently brought up in a lot of talks and

things like that, you know, recently, and of course, if you, in my clinical experience, I see that on a daily basis, you know, serving in the big DFW area here, language barriers can, affect communication, discharge, education, medication management, and follow-up care.

00;08;03;05 - 00;08;43;14

Thuy-Tien Ho

Patients with limited English proficiency may experience delay in treatment, a lower preventative knowledge and worse long-term outcomes, and these are proven by many of the studies that we knew. Studies have also reported worse neurologic outcomes among Spanish-only-speaking stroke survivors compared to English-speaking counterparts, suggesting that language proficiency itself can influence outcomes. And then, of course, additional barriers include, but not limited to, medication costs, transportation challenges, which I mentioned earlier, competing priorities and, you know, live priorities, and then treatment complexity and fragmented care transitions.

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Thuy-Tien Ho

As, you know, you mentioned earlier about when, you know, when we have transitions of care, Anthony.

00;08;49;23 - 00;08;50;18

Craig Beavers

Yeah.

00;08;50;21 - 00;09;13;12

Anthony Rocco

Yeah. Tan, if I could just add to that, I think, you know, in a recent conversation, I was at a state stroke meeting with multiple hospitals in the state where I live, and I was speaking to some of the outpatient stroke APNs, right, that facilitate a clinic, they partner with a vascular neurologist. And I was talking to them about why does it take so long, right, to get an appointment in the clinic, right?

00;09;13;12 - 00;09;31;20

Anthony Rocco

We've got 10 to 14 slots, or whatever that number is, and one of the barriers that they're reporting, and it's something I think we need to take back to our service lines, where I know Craig's a service line leader at his institution, is everyone wants that appointment between 8 and 9, and 4 and 5.30, right? Because now we're asking the patient's family members, or caregivers.

00;09;31;20 - 00;09;58;22

Anthony Rocco

everyone wants that appointment between 8 and 9, and 4 and 5.30, right? Because now we're asking the patient's family members, or caregivers. which suddenly evolved into project managers, right? You know, their role has sort of expanded because they're navigating insurance and navigating all these, sort of new territories, but they have to work. Right? And so from there, you know, they can only bring their family member at 8

o'clock, hopefully, right, and get them back home by 9, so they can make it to the office, or maybe a quick run at lunch. So you'll notice

00;09;58;22 - 00;10;16;01

Anthony Rocco

gaps in the outpatient clinics between certain times, or at least that's been our experience where I live, because family members just can't make it at 11.15 or 2.30. So I think that's something we need to sort of take back.

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Craig Beavers

And just to add on this, Tien, you know, what you've outlined very nicely is clearly that population health gaps and issues are not just you know, healthcare system challenges. There's obviously social determinants of health, which you're alluding to. And so, when we think about all of these aspects, and I think we'll get into the nitty-gritty of certain topics as we go through, what are strategies that you think show the most promise, or just to outline a

00;10;41;17 - 00;10;50;01

Craig Beavers

What are strategies that you think show the most promise or just to outline a kind of high level overview of that?

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Thuy-Tien Ho

Yeah, so as I mentioned earlier, you know, we always have to take huge considerations of the patient's, like, considerations of social determinants of health, which I mentioned some of the, components, earlier, and understanding, you know, make sure that, the patient have access to healthcare, all aspects, whether patients obtain medications, understand treatment plans, attend follow-ups appointments.

00;11;21;04 - 00;11;44;12

Thuy-Tien Ho

participates in, you know, like, rehabilitations, but... and then successfully manage, vascular risk factors, but you know, like, like what you mentioned, the family is a huge component of the stroke patient care, because of, you know, it depends on their disability, degree of disability, so they're going to rely a lot on the family support and things like that. The American Heart Association increasingly recognized

00;11;44;17 - 00;12;18;07

Thuy-Tien Ho

So the promising population level strategies to answer your questions include multidisciplinary care models, stronger care coordination like you mentioned earlier, Anthony. And then telehealth is another one community based support program. I also think a systematic screening for social needs is a big thing out there, because we want to make sure that we meet the patient where they add language, concordance education, professional interpreter services available even for those telehealth visits, medication support programs.

00;12;18;07 - 00;12;46;14

Thuy-Tien Ho

for these patients to, you know, reduce their stroke recurrence. Ultimately, secondary stroke prevention is not limited by the lack of effective therapies. Once again, it is limited by our ability to help the patients access, understand, and sustain those therapies across diverse populations and healthcare settings. So, from the population health perspective, reducing recurrent stroke requires more than just

00;12;46;16 - 00;13;13;21

Thuy-Tien Ho

prescribing the evidence-based therapy. It requires that we're building a system that ensures all stroke survivors, regardless of where they live, what language they speak, or their social-economic circumstances. can access, understand, and sustain those therapy, you know, like, long after they leave the hospital, after they leave the rehab. So the... according to the 2026 American Heart Association scientific statement, it makes it clear that education alone is not enough.

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Thuy-Tien Ho

To reduce the disparity in secondary stroke preventions, we must move beyond simply providing information and focusing on Closing the gaps in access, communications, and long-term support. So, this includes teaching back, to confirm understanding from the patients, or the caregiver. Of course, the Stroke patient depends on their

00;13;41;04 - 00;14;13;08

Thuy-Tien Ho

disability would need the help from, you know, their caretaker. Providing culturally and linguistically appropriate education, actively engaging caregivers and family. I keep... I couldn't emphasize that enough. And then leveraging telehealth to expand the access, and routinely. So, kind of go back to leveraging telehealth to, expand access, is what Anthony was mentioning earlier, that, like. If you have to see the patient in the clinic, sometimes transportations and things like that can...

00;14;13;08 - 00;14;30;13

Thuy-Tien Ho

can affect it, but if you do something like telehealth, then of course the patient may be at home with another family member where the primary care, you know, like the medical decision maker can be on the phone, so that would just give it more options of how we can kind of follow up with these patients. And then routinely screening for social determinants of health, and that is changing, you know, weekly to daily, depends on the patient's circumstances of living.

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Thuy-Tien Ho

That might interfere with adherence and follow-up care. So, I would say that, like, as clinician healthcare system, you mentioned healthcare, you know, like, delivery earlier, and community partners. We have the opportunity to implement proving strategies With all of the things that I mentioned, culturally tailored

educations, because of course we... I mean, living in Dallas, you know, like, we're a mixed cultures here, so we have all different type of background cultures.

00;14;59;08 - 00;15;24;08

Thuy-Tien Ho

Case management-based postal programs, and then, of course. There's a new, thing that not a lot of... and I'm not sure, you know, like, I have to look more into if rural area would have access to these, or only places that would have, like, availability with home blood pressure telemonitoring, because that would just kind of go straight into the system, then you can see the, you know, the action of it.

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Thuy-Tien Ho

Then you can see that, you know, the Asher of it. There's a.

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Anthony Rocco

There's some readmission software, too. Tien, just to jump in quickly, there's some readmission software products, right? We're starting to see a lot of these companies pop up where they promise to monitor patients at 30, 60, and 90 days, and, you know, their blood pressure cuffs are FDA approved, and, you know, the goal is to get those readings to communicate with your EMR or EHR, right? Because you don't want those readings to get lost.

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Anthony Rocco

I'm just looking ahead a bit on the agenda, and I'm seeing one of the topics that Craig will get into is medication persistence, and, you know, I think a lot of us have some experience when these patients are coming back. And oftentimes they think that some medications are really symptom-driven. I don't want to steal Craig's talking points on that, but I just want to turn it over to Craig now a bit. Yeah.

00;16;13;23 - 00;16;14;03

Anthony Rocco

Yeah.

00;16;14;05 - 00;16;34;24

Craig Beavers

No, and just the last thing I would add, and before we transition, Tony, I think the big thing, too, and since you work a lot in analytics, I think population health has to have an analytics component to it to understand where the gaps and the breakdowns are, and not just we know who the population is, but who are the populations that are struggling. what are the places we need to look at interventions and tailoring them, and every site is going to be slightly different, so... Right.

00;16;34;24 - 00;16;53;12

Anthony Rocco

And I think unless you're breaking data down, and I'll turn it back over to you now, but unless you're breaking your data down by race, gender, and ethnicity, it's very safe. You know, it's very easy for you to assume that it's working, right? Because again, we have a bad habit of looking at data in aggregate, but once you start to break it down, you're really starting to see where the opportunities are. I'll turn it over to you, Craig.

00;16;53;14 - 00;16;58;24

Anthony Rocco

But once you start to break it down, you're really starting to see where the opportunities are. I'll turn it over to you, Greg.

00;16;58;28 - 00;17;16;21

Craig Beavers

Let's talk a little bit about medications, because it is a big component when we talk about population health and looking at strategies, and I think this is a great opportunity, both for team members to be engaged in, but again, back to things you're looking at in terms of data, Tony, and what we can use. And, you know, I think the first and foremost piece that we have to think about

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Craig Beavers

is a good... process for medication adherence is making sure that the patients understand what actually they need to be taking. I think that discharge medication history and reconciliation is so critical and so component. We have great data that suggests that a pharmacist or others are engaged in an adequate process that are really outlined, and it goes with some of the things Tien talked about. It's not just

00;17;40;18 - 00;18;01;28

Craig Beavers

It's not just that you've done it, but you've done in a means in a fashion that provides health literacy, have a component of that, and really provides that ability for them to understand what they're taking for, why and when as well as and this is where I think the wills fall off sometimes is who does that get communicated to.

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Craig Beavers

who does that get communicated to that is also going to be helping in the journey, whether that is back to the end, are they going to a skilled nursing facility and making sure that that's the case, their primary care physician, even their own community-based pharmacy that's going to be involved in this? I think there is an opportunity for us to really

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Craig Beavers

break down some of those types of silos as a part of that process. And in relation, during that reconciliation process, another component that a lot of people face is, especially in a stroke, right, or any cardiovascular disease for that matter, is polypharmacy as a whole. And, you know, polypharmacy is a, in my mind, always an interesting construct, because

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Craig Beavers

there is good polypharmacy, and there is bad polypharmacy, and good polypharmacy... and it's still challenging, because it's polypharmacy, and it's, you know, patients may be on 5 or more meds, those 5 or more meds may be appropriate for their indication, but, you know, and then there's bad polypharmacy, where you're on a lot of medications, and what you're alluding to, Tony.

00;19;02;22 - 00;19;19;12

Craig Beavers

they're not sure, is it symptoms? What is it going for? And kind of how do we manage and mitigate that and streamline it? And I think that's really asking ourselves every time that we're encountering the patient, what are they on this for? Does it still need to be warranted? Do we need to change it? And that gets into the facing of deprescribing

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Craig Beavers

And what does deprescribing look like? And of course, there's a large bush around deprescribing, and we won't get into the full context around what that looks like and means, but I think there is an appropriate need in the conversation that we need to have for deprescribing. And I would refer the audience to actually a very timely. American Heart Association scientific statement that was published in circulation this past summer. It was published July 2026. It is about deprescribing in patients with cardiovascular disease by Rob Di Domenico and Joel Mars. It's an outstanding overview of not just polypharmacy, but why

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Craig Beavers

American Heart Association scientific statement that was published in circulation this past summer. It was published July 2026. It is about deprescribing in patients with cardiovascular disease by Rob Di Domenico and Joel Mars. It's an outstanding overview of not just polypharmacy, but why deprescribing needs to be done. And then, of course, there's accessibility, and Dan, you mentioned that. How do we work through the process of making sure patients can afford therapy? What is that going to look like?

00;20;12;09 - 00;20;33;09

Craig Beavers

And then, obviously, depression screening is very critical, because patients, we know this, if we don't screen for depression or other mental health disorders, that can contribute to them not being adhered to their therapy, and that goes a little bit in the domain of social determinants of health, and connecting mental health

disease, and then other cognitive impairment, especially that occurs after stroke, you know, and how do we work with caregivers to do this?

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Craig Beavers

processes, and that is a large topic. We could probably do an entire podcast around medication adherence and polypharmacy and all the things. But I do think some of the other components we're going to talk today eye into this, and that's why I'm excited to get into them. And so, I want to talk a little bit about health literacy, because as I just alluded to, doing discharge education, transitions of care, especially around medication reconciliation, there's that health literacy component. And so.

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Craig Beavers

Kian, what role does health literacy play? And you've kind of started greasing those wheels a little bit, but is there anything you want to... Add specifically into this in terms of sec- specifically secondary stroke prevention?

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Thuy-Tien Ho

Yeah, so it's more like I want to bring it up as more of an awareness, you know, and then we all can work on it, because it's actually one of the most under-recognized barriers to preventing recurring stroke. So, you know, I just want to mention that, like, stroke literacy goes beyond the reading handouts, and the patient needs to understand why their stroke occurred, recognize the warning signs, recurrence, know the purpose of their medication, understand them when seek medication attention.

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Thuy-Tien Ho

And I just want to jump to, you know, how can clinicians improve health literacy in a busy clinical environment? So the good news is that some of the most effective interventions are also some of the simplest, meaning that one of the best tools is actually teach-back, as simple as just talking to the patient, the caregiver, the family, you know, community. Instead of asking, do you understand? Instead, you know, asking, do you understand as a patient.

00;22;02;28 - 00;22;26;23

Thuy-Tien Ho

or the family, or the caregiver to explain their plan in their own words, and then that way you understand what their gaps are, and then this quickly identified, you know, their understanding, and allow us to reinforce, clinicians to reinforce, key messages. For patients with limited English proficiency.

00;22;26;25 - 00;22;50;17

Thuy-Tien Ho

professional interpreter service should be used, you know, whenever possible. So one of the things in health literacy that I wanted to bring up is that it should, you know, it may be subjective, but it should view as a

modifiable stroke risk factor in a way, because as clinicians, we do not assume that education has occurred simply because information was provided. Our responsibility to ensure that information was understood and comprehensive

00;22;50;19 - 00;23;14;28

Thuy-Tien Ho

hand by the patients and their family, the treatment team. So, you know, the discharge summary and things like that, it's well communicated, like you mentioned, Anthony, earlier about, you know, that next appointment with the primary care as soon as possible. So the, you know, the next... so if we want to reduce recurrent stroke, we must move beyond delivering information and start ensuring comprehension. Every patient encounters an opportunity to improve their understanding and strengthen engagement, and reduce the stroke risk. So I just want to, you know, share that much. Thank you.

00;23;15;03 - 00;23;18;12

Thuy-Tien Ho

So I just want to share that much. Thank you.

00;23;18;17 - 00;23;32;25

Anthony Rocco

If I could just add to that, I think, you know, when I used to teach some of the nursing orientation classes, right, I think a lot of us that were in stroke or stroke program management would get pulled in by nursing ed, right, and say, you know, we've got a bunch of new nurses coming in, why don't you give them some background? You know, one of the talking points that we used to use was.

00;23;32;27 - 00;23;55;06

Anthony Rocco

Oftentimes with stroke admissions. This is, in many instances, the first non-elective reason why someone's being admitted to a hospital. Right? And it's disruptive, you know? At 8 o'clock in the morning, they're sitting at their desk. By 11 o'clock that same day, they're in the CAT scan, there's a bunch of neurologists speaking to them, there's a couple of ER residents, and it's overwhelming, right? There's a lot running through them.

00;23;55;06 - 00;24;20;22

Anthony Rocco

Right? And it's disruptive, you know? At 8 o'clock in the morning, they're sitting at their desk. By 11 o'clock that same day, they're in the CAT scan, there's a bunch of neurologists speaking to them, there's a couple of ER residents, and it's overwhelming, right? There's a lot running through them. At the same time, they're watching the morning news, and they're hearing, if you take this medication, this side effect could be happening to you, be careful, proceed with caution. So one of the things that we've done is really

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Anthony Rocco

it's a lot, right? These patients are trying to process, sort of, what the next week or two are going to look like, and they're taking 6 new medications, right? It's usually a new blood pressure pill, it's a higher dose of a current statin, and it could be an anticoagulant. And it's a lot for them to remember, so I

00;24;38;27 - 00;24;58;26

Anthony Rocco

And and it could be an anticoagulant. And it's a lot for them to remember. So I think, you know, as far as teach back. Right. If we just keep it simple and this is not a, you know, a, a highly research method, but it works for us is if we just kind of kept it simple with, why are you taking the med, what's the target?

00;24;58;26 - 00;25;08;20

Anthony Rocco

And what to do when symptoms come back? We've found during our follow up phone calls that patients were able to retain information a little bit better and sort of repeat it back to us.

00;25;08;22 - 00;25;35;23

Craig Beavers

Alright, this has been such a great discussion, it's so rich, and I think One of the areas you can see the culmination of all these conversations that we've just had, Sure. Kind of putting it all together, when you think about this hospital to rehab-to-home. the follow-up that we've talked to, and, you know, I've already alluded around medication reconciliation, what... what is that population health strategy, and how do we navigate this from that standpoint for secondary stroke prevention?

00;25;35;23 - 00;25;42;11

Craig Beavers

What what is that population health strategy. And how do we navigate this from that standpoint for secondary stroke prevention.

00;25;42;12 - 00;26;06;10

Anthony Rocco

Sure, just to sort of briefly summarize our talking points, right? We know that we spent some time talking about acute treatments with pharmacy and some of the great things that are happening on the inpatient side. Tien's talked about some of the work that her and her team are doing, but we know that, really, the recovery happens on the outpatient side, right? Stroke, especially with stroke length of stay, right? The average being between 4 and 6 days, right? There's quite a bit

00;26;06;10 - 00;26;33;03

Anthony Rocco

more that happens after discharge, and it can be overwhelming to family members that are doing a lot of this work. As I mentioned earlier. acute care, inpatient rehab, outpatient therapy, primary care, these are all things

that are essentially separate operating systems, and many patients don't have that shared coordinator, right? We rely on the partner or the spouse to sort of be the project manager for a lot of this, and it can be very overwhelming. So, yes, we put some things in place, right, on the inpatient side to make a lot of this work better.

00;26;33;08 - 00;26;52;23

Anthony Rocco

smoother. We know that meds to beds is great. Greg, you mentioned earlier that there's unit-based pharmacists, which are great, right? I think I'll borrow a line from one of my vascular neurologists who says, every time we speak to a pharmacist, we tend to get smarter, right? Especially with these new CPGs that are out for Stroke care, but it's the reality. Again, a quick and practical no. If you are a provider who's engaging in meds to beds.

00;26;52;24 - 00;27;13;05

Anthony Rocco

Especially with these new CPG center out. Right, for for stroke year. But it's the reality. Again, a quick and practical note if you are a provider who's engaging in medicine beds, please be sure to use the pharmacy that's in the hospital. Please don't be prescribed to a pharmacy that the patient hasn't used in 2 or 3 years, right?

00;27;13;06 - 00;27;36;03

Anthony Rocco

in 2 or 3 years, right? Because that patient, right, needs those medications. Meds to Beds only works if they receive the medications prior to leaving the institution. So just a quick note, and you'll be surprised if you look at your own data, how often that happens, right? Where you're sending these medications, and then the provider leaves the unit, and we're sort of scrambling a bit there, too. Confirming

00;27;36;03 - 00;28;01;05

Anthony Rocco

some of these newer anticoagulants have quite a bit of a copay associated with them, so really engaging pharmacists and some of your APP teams early on. I think a few of us have received phone calls from colleagues whose family members have been discharged, sort of looking for any discount program for some of these new medications. Craig, you mentioned earlier about a handoff to a SNF, right? Some of those

00;28;01;09 - 00;28;24;17

Anthony Rocco

I think that's a really great practice. We know that the medications that are on formulary, on the acute care side, especially with blood pressure medications, are not on formulary at some of our acute and subacute rehab facilities. So when those meds are changed, right. What is the effect of that on the blood pressure goal, especially as we're starting to focus more on some of our ice age, you know, patients with that.

00;28;24;17 - 00;28;47;22

Anthony Rocco

So something to to really consider. Do we have a care everywhere layer in our EHR where the accepting facility can really look at what the plan was on the inpatient side and communicate? Who does the who does the subacute or care facility call when they have a question? Right? Does the vascular neurologist who's caring for that patient have a line?

00;28;47;22 - 00;29;09;18

Anthony Rocco

when they have a question, right? Does the vascular neurologist who's caring for that patient have a line? Is there a back line to the office? Are they supposed to call case management? So, those are really some of the lines of communication that I think would support something better. Again, a lot of what we're going to talk about as we're sort of approaching

00;29;09;18 - 00;29;25;08

Anthony Rocco

you know, the end of the podcast here, things like, you know, making sure that we're calling patients within 2 days. That's a really minimal sort of best practice. I think a lot of programs find that overwhelming, but if you really look at your patient volume, you'll find that if you can carve out 2 to 3 hours a week in your schedule, you'll be able to hit a majority of patients, right? Assuming they're not overwhelmed.

00;29;25;10 - 00;29;54;18

Anthony Rocco

by some of the other phone calls they're getting from the same system, right? I know Patient Experience gives them a call, sometimes the billing office gives them a call as well. So, again, right, you know, underserved and minority populations, you know, oftentimes because of, you know, their current situation, may not be able to, are often sort of deemed vulnerable, right, because of their, their current,

00;29;54;20 - 00;30;18;08

Anthony Rocco

situation, and I think we have an obligation to help them and identify these risk factors early, right? Tien was talking about social determinants of health. A lot of our EMRs have triggers. Are we doing anything about it? Are we changing our programs? As a result, are we investing in the right resources? I think Stroke navigator is sometimes a great term, but let's make sure that we have a clear, functioning role for that stroke navigator, and that we're just not adding more to the stroke coordinator role, right? I mean, that coordinator has a very specific

00;30;18;09 - 00;30;30;06

Anthony Rocco

function, which is different than a, than a navigator role. So, I just open it up to any more questions from you guys about that.

00;30;30;10 - 00;30;40;28

Craig Beavers

Yeah, no, and again, go ahead, and I'll let you add, Tien, to any of your commentary. I just think, again, we could do an entire podcast about transitions of care, so this is just scratching the surface, but Tien, anything that you would add?

00;30;41;05 - 00;31;07;03

Thuy-Tien Ho

No, I just want to comment, I completely agree, and you make some really excellent points, Anthony. So, the most successful transition programs, actually, you know, like you say, do not end at discharge. They provide ongoing support, communications, and accountability across the continuum of Stroke care. So, as much as we can follow, and I, you know, have, study has shown that, like, if the patient can see the primary care, physicians or providers as soon

00;31;07;06 - 00;31;13;23

Thuy-Tien Ho

as possible, things like that will really help facilitate it as well, but you make excellent points, and Craig as well, thank you so much.

00;31;13;25 - 00;31;38;24

Craig Beavers

Yeah, no, and I think... We've done a... yeah, we've done a great job outlining a lot of things. Again, this is high level, it's hard to cover everything in a podcast, and I think the big messaging that I would think about is. What is your population? Using your analytics to understand

00;31;38;24 - 00;32;02;09

Craig Beavers

And I think it is a team based effort. And team based care is alluded to. Having pharmacists, nurse navigators, Anthony or Tony outline health and the Intel health very well patient activation. I think one group we didn't really talk a lot about, but excellent community health workers being engaged in this process. So I think it is a part of the strategy in terms of population health.

00;32;02;09 - 00;32;10;09

Craig Beavers

a part of the strategy in terms of population health. It's just knowing where to go and what to do and what the problem you're trying to challenge. For the last comment, Tien, any final thoughts?

00;32;10;11 - 00;32;19;11

Thuy-Tien Ho

No, I think I... I agree with you. I think we cover most of the points that we would like to make on this,

00;32;19;13 - 00;32;21;13

Craig Beavers

Very good. Tony, final thoughts?

00;32;21;16 - 00;32;45;24

Anthony Rocco

I think this was a great opportunity. I think, obviously, medication adherence, right? Sort of making sure that patients understand that oftentimes these medications are not symptom-based, right, but rather are long, you know, lifelong medications that these patients should be on. That is some of the feedback that we're getting. But I think this is a great opportunity, to talk about this, and I'm grateful to be a part of it.

00;32;45;24 - 00;32;48;08

Anthony Rocco

Thank you.

00;32;48;10 - 00;33;08;27

Craig Beavers

Thank you for joining us for this conversation. A reminder that this episode is the third part of a series of the American Heart Association Secondary Stroke Prevention Podcast. There'll be more episodes that we found at learn.heart.org. Thank you. And please join us for the rest of this journey.